ATTACHMENT #1, OPS MEMO 05-51

SAMPLE MANUAL CERTIFICATION FOR BC PRENATAL PROGRAM

STATE OF WISCONSIN
DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Economic Support

MEDICAID/BADGERCARE CERTIFICATION

(Refer to back for instructions)

[shaded box] = Required fields on all types of certification

TYPE OF CERTIFICATION ACTION

Initial	☒ 1	Amended	☐ 3
Cancel	☐ 4	ID # change	☐ 5

CASE HEAD NAME AND MAILING ADDRESS

Name (last, first, MI): Doe, Jane		
In care of address:		
Street address: 1234 Main St.		
City: Anywhere	State: WI	Zip: 12345

AGENCY NUMBER	W2 AGENCY
040	

CASE NUMBER: 1234567890

MED STAT CODE: F1

PERIOD OF CERTIFICATION

	mo	day	yr
from	01	01	2006
thru	03	31	2006

LAST PREVIOUS ID	CANCEL DATE (mo / day / yr)	NO. OF LINES	WORKER ID
		1	XCTA99

ELIGIBLE CASE MEMBERS

Control name YOB	Name (last, first, MI)	Current ID	Medicare Claim Number
	Doe, Jane	1234567890	

Birthdate	Sex	T18	Liability from date	Liability thru date	NH Liability amt	Date of Death	BAF	Buy-in Action Date (mo / yr)
02/01/1975	F				$			

Control name YOB	Name (last, first, MI)	Current ID	Medicare Claim Number

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					$			

Remarks

I certify that this certification represents the official authorized action of the State Dept. of Workforce Development in accordance with §. 49.95, 49.96, 49.47 and 49.665, Wisconsin statues.

Signature of agency director or authorized representative	Date Signed
Mary Smith (Type In Worker's Name)	01/13/2006

White copy: EDS-F   Yellow copy: County agency case file   Pink copy: County batch

DES-3070 (R. 1/99)